1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7463

CERTIFICATE OF DEATH

07450

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Larmont — Middle: Austin — Last: ALLEN

4. DATE OF DEATH: Month: July — Day: 1 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 29, 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days: 1 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jerome Austin ALLEN

14. MOTHER'S MAIDEN NAME: Althea Imelda Frances PROCTOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Hospital records. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 763.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): Pneumonia — 2 days

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 29, 1959, to July 1, 1959, that I last saw the deceased alive on July 1, 1959, and that death occurred at 2:20 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clayton Norton M.D. — ADDRESS (Street, city or town, state): 95 Cathedral St., Annapolis, Md. — DATE SIGNED: 7/1/59

PHYSICIAN'S NAME (Type): Clayton Norton

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-3-59
22c. NAME OF CEMETERY OR CREMATORY: Our Lady of Sorry
22d. LOCATION (City, town, or county) (State): Owensville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hicks II — ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: JUL 9 '59

24b. REGISTRAR'S SIGNATURE: Catherine L. Krauss

2063221XY4

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7498 CERTIFICATE OF DEATH

Reg. Dist. No. 07451

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Pines on the Severn

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
d. STREET ADDRESS: Pines on the Severn
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Olive — Middle Emma — Last Anderson

4. DATE OF DEATH: Month July — Day 19 — Year 1959

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Feb 28-1876 — 9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Edward S. Lindsay
14. MOTHER'S MAIDEN NAME: Mary Emma Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Brooks Anderson — Address: Chestertown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: about 18 hrs
DUE TO (b): Myocarditis with Fibrillation — a year or more
DUE TO (c): Medrah Arterial Hypertension — Several yrs
4443 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-5-, 1959, to 7-19-, 1959, that I last saw the deceased alive on 7/19-, 1959, and that death occurred at 5:55 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Oliver Purvis M.D. — ADDRESS (Street, city or town, state): Ho Front St Annapolis Md — DATE SIGNED: 7/20/59

PHYSICIAN'S NAME (Type): J. OLIVER PURVIS — Annapolis Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 23-59
22c. NAME OF CEMETERY OR CREMATORY: Rural Cemetery
22d. LOCATION (City, town, or county) (State): Arnold Md

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Taylor Sons — ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: JUL 22 '59
24b. REGISTRAR'S SIGNATURE: Elmer S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07452
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD — b. COUNTY P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mitchellville — 16X-2

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.D.H. - A.A. Hospital
d. STREET ADDRESS: Church Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: — Last: Arnold, Jr.
4. DATE OF DEATH: Month: 7 — Day: 13 — Year: 1959

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12.13. 1914
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Public School
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George T. Arnold, Sr.
14. MOTHER'S MAIDEN NAME: Eleanor Quander

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W.W.# 2
16. SOCIAL SECURITY NO.: 214-40-5590
17. INFORMANT: Mrs. Rachel Pemberton — Address: 4035 Webster St., N.Brentwood, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral injury Arterial Clot — INTERVAL BETWEEN ONSET AND DEATH: Sudden
825X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident - Rt 301
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 7-15 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town): — (County): MAco — (State): MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D.
EXAMINER'S NAME (Type): E. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7-18-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7.23.59
22c. NAME OF CEMETERY OR CREMATORY: Srlington Nat'l. Cem.
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert G. McGuire — ADDRESS: 1820 9th St., N.W. Washington, D.C.
24a. REC'D BY REGISTRAR — DATE: JUL 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7499

CERTIFICATE OF DEATH

Reg. Dist. No. 07453

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cub Hill
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Glen Burnie

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cub Hill
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mary Middle R. Last Baskerville

4. DATE OF DEATH: Month 7 Day 20 Year 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Dec. 12, 1888

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Cub Hill, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elizabeth Bly — Address: Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	TERMINAL BRONCHOPNEUMONIA	24 HRS.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	ARTERIOSCLEROTIC CARDIO-VASC. DISEASE	3 YEARS
DUE TO (c)	~~CERE~~ GENERALIZED ARTERIOSCLEROSIS	10 YEARS

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SENILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DEC 9, 1958 to JULY 20, 1959, that I last saw the deceased alive on JULY 20, 1959, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Lankford Jr. M.D.

ADDRESS (Street, city or town, state): Mountain Rd.

DATE SIGNED: 7-20-59

PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR MD — Pasadena, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-24-59

22c. NAME OF CEMETERY OR CREMATORY: Asbury

22d. LOCATION (City, town, or county) (State): Adamstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas E. Kelbaugh — ADDRESS: 1303 Maryland

24a. REC'D BY REGISTRAR DATE: JUL 22 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7465 CERTIFICATE OF DEATH

Reg. Dist. No. 07454

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hospital
d. STREET ADDRESS: 10 Springknoll Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Theodore; Middle: ; Lost: BEALL
4. DATE OF DEATH: Month: July; Day: 14; Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 11, 1914
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elec. Eng.
10b. KIND OF BUSINESS OR INDUSTRY: G.+E.Co.
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Alloysius J. Beall
14. MOTHER'S MAIDEN NAME: Katherine Muller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-05-4776
INFORMANT: Mrs. Anna V. Beall
Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/14/59, 19___, to 7/14/59, 19___, that I last saw the deceased alive on July 14, 1959, and that death occurred at 4:55P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin Davis Jr. M.D.
ADDRESS (Street, city or town, state): 98 Cathedral St., Annapolis, Md.
DATE SIGNED: 7/15/59
PHYSICIAN'S NAME (Type): Edwin Davis, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 17, 1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
22d. LOCATION (City, town, or county) (State): Brooklyn MD

23. FUNERAL DIRECTOR'S SIGNATURE: P. L. Singleton
ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: JUL 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7500

CERTIFICATE OF DEATH

Reg. Dist. No. 07455

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 3 years 4 mo. 7days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3Y01-4
d. STREET ADDRESS: 837 W. Lexington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Hollie; Middle; Last Bell

4. DATE OF DEATH: Month 7; Day 12; Year 19 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/18/1913

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest Preston

14. MOTHER'S MAIDEN NAME: Ellena Nic hols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia — 171X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of Cervix
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 026X Central Nervous System Syphilis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---

20c. TIME OF INJURY Month, Day, Year Hour p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from 3/5, 19 56, to 7/12 A., 19 59, that I last saw the deceased alive on 7/12, 19 59, and that death occurred at 11:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 7/13/59

PHYSICIAN'S NAME (Type): L. Benedict, M. D.
Crownsville State Hospital, Md. 7/13/59

22a. BURIAL, CREMATION, REMOVAL (Specify): [signature]
22b. DATE THEREOF: 7-16-59
22c. NAME OF CEMETERY OR CREMATORY: [signature]
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Pate R. Wilhelm
ADDRESS: 322 [illegible]

24a. REC'D BY REGISTRAR DATE JUL 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7466 **CERTIFICATE OF DEATH** 07456

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: Visit
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Weems Creek

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): York
d. STREET ADDRESS: 5068 Pershing Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Shower — Last: Beltz Jr.

4. DATE OF DEATH: Month: July — Day: 17 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 1, 1936

9. AGE (In years last birthday): 22 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician

10b. KIND OF BUSINESS OR INDUSTRY: USAF Band

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Harry Shower Beltz Sr.

14. MOTHER'S MAIDEN NAME: Florence Dick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1954-1959

16. SOCIAL SECURITY NO.: 185-28-1726

17. INFORMANT — Address: Official Air Force Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH:
929.8
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Drowned while swimming

20c. TIME OF INJURY Hour o. m.: 0030 — Month, Day, Year: July 17 19 59

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Weems Creek

20f. (City or town) (County) (State): Annapolis Arundel Maryland

21. I certify that I attended the deceased from NEVER, 19____, to NEVER, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 0030A M, from the causes and on the date stated above.

Reviewed remains upon arrival - See reverse

ACTUAL SIGNATURE: Heino Trees M.D. — ADDRESS (Street, city or town, state): USAF HOSPITAL ANDREWS — DATE SIGNED: 17 Jul 59

PHYSICIAN'S NAME (Type): HEINO TREES MD — WASHINGTON 25, D. C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-22-59
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): York, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Rinaldi Funeral Home Inc. 816-H-ST NE [Wash. D.C.

24a. REC'D BY REGISTRAR — DATE: JUL 22 '59
24b. REGISTRAR'S SIGNATURE: Carlton S. Knowles

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

CERTIFICATE

I the undersigned, Emergency Doctor, USAF Hospital Andrews, affirm that the remains were received from US Naval Hospital Annapolis Maryland at 1300 hours 17 Jul 59.

The Coroner, Arundel County, released remains to service control and desired that the Death Certificate be prepared by service facility performing the autopsy.

Jurisdiction over remains was released to and accepted by USAF Hospital Andrews, Andrews AFB, Camp Springs, Prince Georges County, Maryland.

Cause of death confirmed by autopsy.

HEINO TREES MD
Emergency Doctor

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7501 Items 3,13 See note from funeral Direc. on back of Cert. et

CERTIFICATE OF DEATH

Reg. Dist. No. 07457

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 12hrs.15min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 330 Cannon
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Merritt — Middle John Berryman ~~Berman~~ — Last ~~Berman~~

4. DATE OF DEATH: Month 7 — Day 2 — Year 1959

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/13/06
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John ~~Berman~~ Berryman
14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Yes.
INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure
410 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Chronic Mitral Stenosis
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Lobar Pneumonia
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------
20c. TIME OF INJURY Month, Day, Year — Hour o. m. ----- p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): --------
20f. (City or town) (County) (State): -------

21. I certify that I attended the deceased from 7/1/59, 19____, to 7/2, 1959, that I last saw the deceased alive on 7/2, 1959, and that death occurred at 3:30A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 7/2/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md. — 7/2/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/6/59
22c. NAME OF CEMETERY OR CREMATORY: James Cemetary
22d. LOCATION (City, town, or county) (State): Near Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wallen — ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: JUL 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kenny

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Please note - Correct spelling for the deceased last name is

BERRYMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7502

CERTIFICATE OF DEATH

Reg. Dist. No. 07458

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4 years 6mo. 29 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V014
d. STREET ADDRESS: 2227 Etting Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Edna Earl — Last: Booker

4. DATE OF DEATH: Month: 7 — Day: 7 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-Vascular Accident
443 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Cardiovascular Disease
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ----------

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----------

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 -------

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -------

20f. (City or town) (County) (State) -------

21. I certify that I attended the deceased from 12/8 19 54, to 7/7 19 59, that I last saw the deceased alive on 7/7 19 59, and that death occurred at 6:28 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 7/7/59

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md. — 7/7/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 7-10-59 — 22c. NAME OF CEMETERY OR CREMATORY: Mt Calvary — 22d. LOCATION (City, town, or county) (State): A A Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: C Halstead — ADDRESS: 9/8 Lan Hill Ave

24a. REC'D BY REGISTRAR DATE: JUL 9 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7467

07459

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 209 N. Washington St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 10
d. STREET ADDRESS: 209 N. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: E. — Last: Bowie

4. DATE OF DEATH: Month: 7 — Day: 19 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-20-1876

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Calvert Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Augustus Bowie

14. MOTHER'S MAIDEN NAME: Tempie Randall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mamie F. Bowie — Address: Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
561.0
DUE TO (b): Strangulated Left Inguinal Hernia
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 24 hr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/18/59, 19, to 7/19/59, 19, that I last saw the deceased alive on 7/19/59, 19, and that death occurred at 2:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. Littlechild M.D.

ADDRESS (Street, city or town, state): 110 C. First Annapolis Md.

DATE SIGNED: 7/20/59

PHYSICIAN'S NAME (Type): HE

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-23-59

22c. NAME OF CEMETERY OR CREMATORY: Fowlers

22d. LOCATION (City, town, or county) (State): Best Gate, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, II — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: JUL 21 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7503

CERTIFICATE OF DEATH

Reg. Dist. No. 27 07460

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft George G. Meade
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Randallstown 03X-2
d. STREET ADDRESS: 8622 Church Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EMIL — Middle JAMES — Last BRANDON

4. DATE OF DEATH: Month July — Day 26 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8 Oct 1892

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Brandon

14. MOTHER'S MAIDEN NAME: Corinne Alberta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 116-12-3491

17. INFORMANT: Son — Address: 8622 Church Lane Randallstown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH
443X
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Hypertensive Cardiovascular disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 26 July, 19 59, to 26 July, 19 59, that I last saw the deceased alive on 26 July, 19 59, and that death occurred at 1135A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Roger C Moyer M.D. — ADDRESS (Street, city or town, state): U.S.Army Hospital, Ft Meade, Md — DATE SIGNED: 26 Jul 59

PHYSICIAN'S NAME (Type): ROGER C. MOYER, Capt, MC, U.S.Army Hospital, Ft George G. Meade, Md 26Jul59

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

22b. DATE THEREOF: 7-27-59

22c. NAME OF CEMETERY OR CREMATORY: Fresh Pond Crematory

22d. LOCATION (City, town, or county) (State): Maspeth, Long Island, New York

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: William Cook, Inc., 1217 St.Paul Street

24a. REC'D BY REGISTRAR DATE: JUL 28 '59

24b. REGISTRAR'S SIGNATURE: Charles L Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7468 **CERTIFICATE OF DEATH** 07461

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: The Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: Box 273-A Annapolis Neck Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Tyrone — Middle: Anthony — Last: Brown

4. **DATE OF DEATH**: Month: July — Day: 8 — Year: 19 59

5. SEX: Male — 6. COLOR OR RACE: Negro — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: July 7, 1959 — 9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours 9, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Archie Curnell Brown
14. MOTHER'S MAIDEN NAME: Helen Flontina Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Mother — Address: Box 273A, Annapolis Neck Rd., Annapolis Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity
776x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from July 7, 19 59, to July 8, 19 59 that I last saw the deceased alive an July 8, 19 59, and that death accurred at 12:20 AM, fram the causes and an the date stated abave.

ACTUAL SIGNATURE: R. L. Richardson M.D. — ADDRESS (Street, city or town, state): 110 Clay St Annapolis — DATE SIGNED: 7/9/59

PHYSICIAN'S NAME (Type): Dr. R. L. Richardson — Clay St., Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 7-10-59 — 22c. NAME OF CEMETERY OR CREMATORY: Brewer Sill — 22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Leese — ADDRESS: Annap. Md.
24a. REC'D BY REGISTRAR DATE: JUL 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Evans

2163237XVO

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7469

CERTIFICATE OF DEATH

07462

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Anne Arundel General Hospital	d. STREET ADDRESS: 7 West Elliott Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First John, Middle, Last Buser	4. DATE OF DEATH: Month July, Day 9, Year 19 59
5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Dec. 16, 1910 — 9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STORE KEEPER — 10b. KIND OF BUSINESS OR INDUSTRY: GROCERIES	11. BIRTHPLACE (State or foreign country): Illinois — 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: HENRY BUSER	14. MOTHER'S MAIDEN NAME: ELISE MOHLER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.	INFORMANT: Elizabeth S. Buser — Address (2)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Partial intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH

197.9

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) (operated) — 1 mon

DUE TO (c) Malignant Salivary Mesothelioma — 3 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. — 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Dec ____, 195__, to 7-9-, 19 59, that I last saw the deceased alive on 7-9-59, 19____, and that death occurred at 11.50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley M.D. — ADDRESS (Street, city or town, state): 124 Cathedral St — DATE SIGNED: 7-10-59

1

PHYSICIAN'S NAME (Type): Frank M Shipley — Annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: July 12-59 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff — 22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md — 24a. REC'D BY REGISTRAR DATE: JUL 13 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07463

7504

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Laurel, Md.
c. LENGTH OF STAY IN 1b: 1 yr. 4 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: District Training School, Children's Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47X-3
d. STREET ADDRESS: 1322 - 11th St. N.W., Apt. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marian — Middle: Elaine — Last: Byrd

4. DATE OF DEATH: Month: July — Day: 1 — Year: 1959

5. SEX: female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/16/54

9. AGE (In years last birthday): 4 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter Edward Byrd

14. MOTHER'S MAIDEN NAME: Barbara E. Law

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Children's Center, Laurel, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial pneumonia - partial atalectasis - lft. — 351X
DUE TO
(b): cerebral palsy - rigidity quadriplegia
DUE TO
(c): mental retardation - severe

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): --

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. / p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): --

20f. (City or town) (County) (State): --

21. I certify that I attended the deceased from February 28, 1958, to July 1, 1959, that I last saw the deceased alive on July 1, 1959, and that death occurred at 10:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilfred R. Ehrmantraut M.D.
ADDRESS (Street, city or town, state): Children's Center, Laurel, Md.
DATE SIGNED: 7/1/59

PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 7-6-59
22c. NAME OF CEMETERY OR CREMATORY: Lincolnia Mem.
22d. LOCATION (City, town, or county) (State): Hyattsville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ambrose B. Boyd
ADDRESS: 1238 - 20th St N.W.

24a. REC'D BY REGISTRAR
DATE: JUL 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07464

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Meade
c. LENGTH OF STAY IN 1b: One hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Building #4554

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Gardens, Glen Burnie
d. STREET ADDRESS: 99 Glen Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jesse Middle J. Last Cassady

4. DATE OF DEATH: Month July Day 15th. Year 19 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/9/96

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Civil Service

11. BIRTHPLACE (State or foreign country): Blackburg, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James W. Cassady

14. MOTHER'S MAIDEN NAME: Magdalena Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): World War (If yes, give war or dates of service): I

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Elvie Effinger Cassady — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occludion
DUE TO (b): 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. — 7/15/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 18 July '59
22c. NAME OF CEMETERY OR CREMATORY: Westview Cem.
22d. LOCATION (City, town, or county) (State): Blacksburg, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Richard V. Singleton
ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: JUL 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7470

CERTIFICATE OF DEATH

Reg. Dist. No. 07465

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 608 Arlington Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: — Last: COLEMAN

4. DATE OF DEATH: Month: July — Day: 7 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 12, 1885

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Corbett

14. MOTHER'S MAIDEN NAME: Celestine Curran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Robert C. Adams — Address: 407 Lakeview Ave, Mayo, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
493x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus, Cerebral vascular accident.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/6, 19 59, to 7/7/59, 19 ___, that I last saw the deceased alive on 7/7/59, 19 ___, and that death occurred at 7:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N. Peeler M.D. — ADDRESS (Street, city or town, state): 121 Cathedral St., Annapolis, Md. — DATE SIGNED: 7/7/59

PHYSICIAN'S NAME (Type): Richard N. Peeler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 10, 1959
22c. NAME OF CEMETERY OR CREMATORY: Columbia Gardens,
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert F. Murphy — ADDRESS: 3524 Columiba Pike, Arl. Va.

24a. REC'D BY REGISTRAR DATE: JUL 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7471

CERTIFICATE OF DEATH

07466

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 15 Years
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: U.S.Naval Hospital, Annapolis,Md.

2. USUAL RESIDENCE (Where deceosed lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 107 Clay Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas — Middle Lewis — Last CROCKER

4. DATE OF DEATH: Month July — Day 24 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 4-30-01

9. AGE (In years lost birthday): 58 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.Navy

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy

11. BIRTHPLACE (State or foreign country): Rhode Island

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Rev. Thomas Lewis CROCKER

14. MOTHER'S MAIDEN NAME: Belle Rainy Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: U.S.Naval Hospital, Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): INTRA-CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 10½ hours
331x
DUE TO
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.
(b): ESSENTIAL HYPERTENSION
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-24, 19 59, to 7-24, 19 59, that I last saw the deceased alive on 7-24, 19 59, and that death occurred at 6:20P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: for R J Bunch LT MC USNR — M.D. — ADDRESS (Street, city or town, state): USNaval Hospital, Annapolis,Md. — DATE SIGNED: 7-25-59

PHYSICIAN'S NAME (Type): for R. I. HOCHMAN LCDR MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 7-29-59

22c. NAME OF CEMETERY OR CREMATORY: Annapolis Natl.

22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: Anna. Md.

24a. REC'D BY REGISTRAR DATE: JUL 27 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7472

CERTIFICATE OF DEATH

Reg. Dist. No. 07467

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Genera l Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Rural - Severn
d. STREET ADDRESS: Rt-1, Box-230
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: J ames — Middle: H. — Last: CROUSE, SR.

4. DATE OF DEATH: Month: July — Day: 28 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 18, 1892

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James H. Crouse

14. MOTHER'S MAIDEN NAME: Anna M. Crouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.:

INFORMANT: Mr. James H. Crouse JR; Address: SAME AS 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gen. Carcinomatosis - primary
DUE TO
199.2
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): site unknown — 2 mos.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I ottended the deceased from July 24, 1959, to July 28, 1959, that I lost sow the deceased olive on July 28, 1959, ond that deoth occurred at 8:45P M, from the couses ond on the dote stoted obove.

ACTUAL SIGNATURE: S. Borssuck M.D.
ADDRESS (Street, city or town, stote): Amos Garrett Blvd.,
DATE SIGNED: 7/29/59

PHYSICIAN'S NAME (Type): Samuel Borssuck
Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/1/59
22c. NAME OF CEMETERY OR CREMATORY: Baldwin Memorial
22d. LOCATION (City, town, or county) (Stote): Millersville, AA. Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hopping & Kirkley Glen Burnie, Md

24a. REC'D BY REGISTRAR DATE: JUL 31 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours of death. Page 4 may be retained by the haspitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to buriol, cremation, or removal, and in any event within 72 hours ofter death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7506

CERTIFICATE OF DEATH

Reg. Dist. No. 07468

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b 4 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4
d. STREET ADDRESS 2219 N. Howard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Charles Middle Davis Last
4. DATE OF DEATH Month July Day 1 Year 1959

5. SEX M.
6. COLOR OR RACE C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-2-1874
9. AGE (In years last birthday) 90 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?
10b. KIND OF BUSINESS OR INDUSTRY ?
11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Address Ethel Johnson Davis 2219 N. Howard

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heat Stroke. — INTERVAL BETWEEN ONSET AND DEATH

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Cardio vascular Disease
DUE TO (c) Arteriosclerotic Cardio Vascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-24, 1959, to 6-24, 1959, that I last saw the deceased alive on 6-24, 1959, and that death occurred at 6 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Fobbs Grunberg M.D. ADDRESS (Street, city or town, state) P.O Box 37 Odenton Md DATE SIGNED 7/1/59

PHYSICIAN'S NAME (Type) Fobbs Grunberg

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7/6/59
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.
22d. LOCATION (City, town, or county) (State) Balto Md.

23. FUNERAL DIRECTOR'S SIGNATURE Halsted-Mauck ADDRESS 918 Druid Hill Ave
24a. REC'D BY REGISTRAR DATE JUL 7 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7473 **CERTIFICATE OF DEATH** Reg. Dist. No. 07469

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION A. A. General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x East Port
d. STREET ADDRESS 306 Chester Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Emma Middle Last Davis

4. DATE OF DEATH Month 7 Day 25 Year 1959

5. SEX Female
6. COLOR OR RACE Col.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10-8-1904
9. AGE (In years last birthday) 54 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co Owner Tavern
10b. KIND OF BUSINESS OR INDUSTRY Tavern
11. BIRTHPLACE (State or foreign country) A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Vermont Brown
14. MOTHER'S MAIDEN NAME Alice Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT George Davis Address East Port

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction
420.1
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH Hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 2-24 7/25, 1959, to 2-25 7/25, 1959, that I last saw the deceased alive on 7/25, 1959, and that death occurred at 2-56 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE John L. Hedeman M.D. ADDRESS (Street, city or town, state) 121 Cathedral St. Annapolis Md DATE SIGNED 7/25/59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7-28-59
22c. NAME OF CEMETERY OR CREMATORY Annapolis Neck
22d. LOCATION (City, town, or county) (State) Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Reese ADDRESS Annapolis Md.
24a. REC'D BY REGISTRAR DATE JUL 27 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG244 7-20-59 et

7474

CERTIFICATE OF DEATH

07470

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE-ARUNDEL GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: VA. b. COUNTY: MECKLENBURG
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chase City - 83X 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

063

3. NAME OF DECEASED (Type or print): First FANNIE Middle ELIZABETH Last DAVIS

4. DATE OF DEATH: Month JULY Day 5 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: COLORED
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 3- 1885
9. AGE (In years last birthday): 74 73
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper — Never Worked
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chase-City VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles W. DAVIS
14. MOTHER'S MAIDEN NAME: Henrietta PURYEAR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
INFORMANT: Dr. Harvey F. DAVIS - Address: RT. 3 - BOX 181A, ANNA, Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure
DUE TO (b): Hypertensive Cardio-Vascular Disease
DUE TO (c): Chronic Nephrosclerosis

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/30, 1959, to 7/5, 1959, that I last saw the deceased alive on 7/5, 1959, and that death occurred at 1230A M, from the causes and an the date stated abave.

ACTUAL SIGNATURE: Theodore W. Johnson M.D.
ADDRESS (Street, city or town, state): 32 Calvert Street, Annapolis, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): DR. THEODORE W. JOHNSON

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7-9-59
22c. NAME OF CEMETERY OR CREMATORY: Bethlehem
22d. LOCATION (City, town, or county) (State): Chase City VA.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hicks III
ADDRESS: Annapolis - Md.

24a. REC'D BY REGISTRAR DATE: JUL 10 '59
24b. REGISTRAR'S SIGNATURE: Clarence E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7475

CERTIFICATE OF DEATH

07471

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hospital

063

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 704 Wells St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irene; Middle:; Last: DAVIS

4. DATE OF DEATH: Month: July; Day: 28; Year: 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-29-1882

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

I

13. FATHER'S NAME: David Dorsey

14. MOTHER'S MAIDEN NAME: Mary Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Ida Holland — Address: Annap. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetes Mellitus & Pulmonary Edema
DUE TO (b): Central Edema
DUE TO (c): Arterial Sclerotic Heart Disease

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from April 22, 1959, to July 28, 1959, that I last saw the deceased alive on July 28, 1959, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Richardson M.D. — ADDRESS (Street, city or town, state): 110 Clay St., — DATE SIGNED: 7/29/59

PHYSICIAN'S NAME (Type): R. L. Richardson — Annapolis, Md.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-31-59

22c. NAME OF CEMETERY OR CREMATORY: Carters

22d. LOCATION (City, town, or county) (State): Friendship

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, II — ADDRESS: Annap. Md

24a. REC'D BY REGISTRAR DATE: JUL 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7476

CERTIFICATE OF DEATH

Reg. Dist. No. 07472

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1808 Lincoln Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sherman — Middle: — Last: DORSEY

4. DATE OF DEATH: Month: July — Day: 19 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-8-1905

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James G. Dorsey

14. MOTHER'S MAIDEN NAME: Mary Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mary Dorsey — Address: 1808 Lincoln Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the prostate With Metastases
DUE TO (b): to Pelvis & Peri aortic Lymph Nodes
DUE TO (c): and bones of Pelvis & Spine

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive Heart Failure

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour o. m. p. m., 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 14th, 19 59, to July 19th, 19 59, that I last saw the deceased alive on July 19th, 1959, and that death occurred at 9:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Richardson M.D.

ADDRESS (Street, city or town, state): 110 Clay St., Annapolis, Md.

DATE SIGNED: 7/20/59

PHYSICIAN'S NAME (Type): R. L. Richardson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-23-1959

22c. NAME OF CEMETERY OR CREMATORY: Carters Methodist

22d. LOCATION (City, town, or county): Friendship (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. Reese #108

ADDRESS: Wash. St. Annapolis, Md.

24a. REC'D BY REGISTRAR: DATE: JUL 21 '59

24b. REGISTRAR'S SIGNATURE: Clifford B. Travers

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7507

CERTIFICATE OF DEATH

08647

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Drury
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION: --

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Drury
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle Emily Last DRURY

4. DATE OF DEATH: Month July Day 9, XXX Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: (Day Unknown) March 1870

9. AGE (In years) If under birthday) 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Schoolteacher

10b. KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James O. Drury, Sr.

14. MOTHER'S MAIDEN NAME: Elizabeth Mayhew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Mr. James O. Drury, Jr. Address 3110 Penna Ave S.E., Wash 20, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o): Arteriosclerosis, generalized, severe — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

450.0

DUE TO (b):

Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1946, to July 9, 1959, that I last saw the deceased alive on July 6, 1959, and that death occurred at 11:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. B. Sasscer M.D.

ADDRESS (Street, city or town, state): Upper Marlboro, Maryland

DATE SIGNED: 7/9/59

PHYSICIAN'S NAME (Type): R. B. Sasscer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/11/59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery

22d. LOCATION (City, town, or county) (State): Upper Marlboro Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ritchie Bros. Upper Marlboro, Md.

24a. REC'D BY REGISTRAR DATE: AUG 11 '59

24b. REGISTRAR'S SIGNATURE: Clarence L. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7508 Items 8,14 FilmG246 7-31-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 07473

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10 Brookfield Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena
d. STREET ADDRESS: 10 Brookfield Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LENA — Middle — Last ELLISON

4. DATE OF DEATH: Month July — Day 23 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 18, 1866

9. AGE (In years last birthday): 93 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William B. Stinchcomb

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mrs Nellie Stallings, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 10 YEARS

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) GENERALIZED ARTERIOSCLEROSIS — 20 YEARS

DUE TO (c) SENILITY — 15 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from July 23, 1959, to ——, 19——, that I last saw the deceased alive on ——, 19——, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Lankford Jr. M.D. — ADDRESS (Street, city or town, state): Mountain Road — DATE SIGNED: 7-23-59

PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR M.D. — Pasadena, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/26/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
22d. LOCATION (City, town, or county) (State): Pasadena, AA, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hopping and Kirkley, Glen Burnie, Md.

24a. REC'D BY REGISTRAR — DATE: JUL 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

7509

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07474
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: 7 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Arunde[illegible] Beach

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — COUNTY: ------
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 220 E. 25th,st.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mrs. Middle S. Last Elizabeth Fisher
4. DATE OF DEATH: Month July Day 12th. Year 1959

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	W	MARRIED ☒	12/16/05	53 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Arthur C. Adams
14. MOTHER'S MAIDEN NAME: Helen Bueschel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT (Address): Mr. John L. Fisher (Husband)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7/12/59
EXAMINER'S NAME (Type): Gustave H. Faubert M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	July 15-59	Loudon Park	Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Peterman & York	2224 N. Charles	JUL 14 '59	Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of items is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1 M I

7510 — **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** — 07475

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A. A. — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old Annap. Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: A. A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena.

d. STREET ADDRESS: Old Annapolis

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: WILLIAM Middle: H. Last: FORD.

4. DATE OF DEATH Month: JULY Day: 30 Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-10-83

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: U.S.C.G.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Unk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CORONARY THROMBOSIS	48 HOURS
420.1 DUE TO (b)	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	2 YRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	GENERALIZED ARTERIOSCLEROSIS	5 YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CEREBRAL ARTERIOSCLEROSIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JULY 25, 1959, to JULY 29, 1959, that I last saw the deceased alive on JULY 29, 1959, and that death occurred at 8:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Lankford Jr. M.D. — ADDRESS (Street, city or town, state): Mountain Rd Pasadena, Maryland — DATE SIGNED: 7-30-59

PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b. DATE THEREOF: 8-3-59

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county): Balt. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Funeral Home

24a. REC'D BY REGISTRAR DATE AUG 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. [illegible]

1 30 Ct. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7477 **CERTIFICATE OF DEATH** Reg. Dist. No. 07476

1. PLACE OF DEATH
o. COUNTY A.A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Severn Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis
d. STREET ADDRESS 11 Severn Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Bertha Middle Bright Last Frances
4. DATE OF DEATH Month July Day 16 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Mar-29-1890
9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Bright
14. MOTHER'S MAIDEN NAME Lucy Austin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Lyle Carraway Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis
331x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__ to July 16, 1959, that I last saw the deceased alive on ____, 19__, and that death occurred at ____ M, from the causes and on the date stated above.
ACTUAL SIGNATURE M.D. ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type) E. L. Atwood

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF July 18-59
22c. NAME OF CEMETERY OR CREMATORY St Annes Cemt
22d. LOCATION (City, town, or county) (State) Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE Owen M. Taylor Sons ADDRESS Annapolis Md.
24a. REC'D BY REGISTRAR DATE JUL 20 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 FilmG244 7-13-59 ams

7511

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item7 FilmG244 7/13/59 cap

07477

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Earleigh Hgts. Rd. S. of Ritchie Hgwy.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~XXXXXXXX~~ Pasadena
d. STREET ADDRESS: Hamburg and Light Streets
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALBERT — Middle: MARION — Last: FRIEND
4. DATE OF DEATH: Month: July — Day: 1 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 14, 1889
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Robert Friend
14. MOTHER'S MAIDEN NAME: Julia Hampton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs Marian Snoberger, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Exsanguination due to severed femoral artery — INTERVAL BETWEEN ONSET AND DEATH:
812.X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Pedestrian struck by auto
20c. TIME OF INJURY: Hour: ? a. m. p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town): Pasadena — (County): A.A. — (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Charles S Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 7/1/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/3/59
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d. LOCATION (City, town, or county) (State): Glen Burnie, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping & Kirkley by Kirkley
ADDRESS: Glen Burnie
24a. REC'D BY REGISTRAR — DATE: JUL 6 '59
24b. REGISTRAR'S SIGNATURE: Collins L Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

85 6-2200

Items 19&20 Film 246 8-12-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07478

CERTIFICATE OF DEATH

Reg. Dist. No. 27

7512

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Ft George G. Meade
d. STREET ADDRESS: NSA
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JERRY	L.	GARMON	15 July		19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cau		26 Oct 1936	22 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seaman	U.S. Navy	Missouri	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Donald Laverne Garmon	Marion Rachiel (last name unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes entered 4 Feb 54	490-44-9944	Military Records NSA, Ft Meade, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hemorrhage	
DUE TO		
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last. (b)	Gunshot Wounds of Abdomen	4 hrs
DUE TO (c)		

981X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Gunshot -- Homicide

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
0245 19		Waterloo Md Parked	Waterloo	Anne Arundel	Md

21. I certify that I attended the deceased from 15 July, 19 59 to 15 July, 19 59, that I last saw the deceased alive on 15 July, 19 59, and that death occurred at 0645 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE	M.D.	ADDRESS (Street, city or town, state)	DATE SIGNED
Howard Bob Mass Capt.	M.C.	U.S.Army Hospital, Ft Meade, Md	15 Jul 59

PHYSICIAN'S NAME (Type) HOWARD BOB MASS, Capt, MC U.S.Army Hospital, Ft George G. Meade, Md

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	7/16/59	Pleasant Grove	Gorin, Mo.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Wm. Cook, Inc., 1217 St. Paul St., Balto., Md.	JUL 20 '59	Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7513 **CERTIFICATE OF DEATH** 07479

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 9 mo,18 d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Balto. 3V01-4
d. STREET ADDRESS: 1514 N. Fulton Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mabel — Middle — Last Goodman

4. DATE OF DEATH: Month July — Day 3 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 1905

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Henry Baker

14. MOTHER'S MAIDEN NAME: Bertha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Medical Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial insufficiency
4222
DUE TO
(b): Fatty degeneration of myocardium
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/16, 19 58, to 7/3, 19 59 that I last saw the deceased alive on 7/3, 19 59, and that death occurred at 6:08 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Crownsville, Md. DATE SIGNED: 7/5/59

PHYSICIAN'S NAME (Type): Dr. Ludwig Benedict Crownsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/8/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
22d. LOCATION (City, town, or county) (State): Anne Arundel County Md

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: 918 Druid Hill Ave.

24a. REC'D BY REGISTRAR DATE: JUL 7 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08654

7514

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2 mo. 26 da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head, Md. 08 x 3
d. STREET ADDRESS: Rt. 1, Box 110
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ (?)

3. NAME OF DECEASED (Type or print): First: James — Middle: D. — Last: Gutrick

4. DATE OF DEATH: Month: 7 — Day: 30 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-7-82

9. AGE (In years last birthday): 76? yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Government Worker

10b. KIND OF BUSINESS OR INDUSTRY: - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: - -

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
442 x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive Arteriosclerotic Cardiovascular Renal disease & Cardiomegaly.
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 5/4, 19 59, to 7/30, 19 59 that I last saw the deceased alive on 7/30, 19 59, and that death occurred at 11:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville State Hosp., Md. — DATE SIGNED: 7/31/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M.D. — Crownsville State Hosp., Md. — 7/31/59

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 8-5-59

22c. NAME OF CEMETERY OR CREMATORY: Zion Bap ch

22d. LOCATION (City, town, or county) (State): Hill Top, Chas. Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Montgomer Bro. — ADDRESS: 913 Flaver

24a. REC'D BY REGISTRAR DATE: 54 AUG 10 59

24b. REGISTRAR'S SIGNATURE: 54 Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7515 **CERTIFICATE OF DEATH** Reg. Dist. No. 07480

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1year 10mo. 22days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 1644 E. Pratt Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Charles — Middle Thomas — Last Hall

4. DATE OF DEATH: Month 7 — Day 14 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/22/13

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Tate Hall

14. MOTHER'S MAIDEN NAME: Helen Roberta Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
442 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Nephrotic Syndrome
DUE TO (c): Hypertensive Cardiovascular Renal Disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----------

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. ----- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -------

20f. (City or town) (County) (State): ------

21. I **certify** that I attended the deceased from 8/22, 1957, to 7/14, 1959, that I last saw the deceased alive on 7/14, 19 59, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 7/14/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md. — 7/14/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 16, 1959
22c. NAME OF CEMETERY OR CREMATORY: Mount Calvary
22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edward C. Wilson — ADDRESS: 2004 Pulaski Hwy Baltimore Md

24a. REC'D BY REGISTRAR DATE: JUL 16 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7516 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08655
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 25
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5920 Bellegrove Rd.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: / Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gertie — Middle: — Last: Hall

4. DATE OF DEATH: Month: July — Day: 23rd. — Year: 19 59

5. SEX: F

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: ?

9. AGE (In years last birthday): 75 ? yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (domestic)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ?

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: ?

17. INFORMANT — Address: Mrs.Edith Howard (same address as deceased)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): General arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

450.0

DUE TO (b): General asthenia — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 7/23/59

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): —

22b. DATE THEREOF: 8.25.59

22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS:

24a. REC'D BY REGISTRAR — DATE: AUG 27 59

24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7478 **CERTIFICATE OF DEATH** Reg. Dist. No. 07481

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2017 Forest Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 2017 Forest Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Hattie Middle Last Hall
4. DATE OF DEATH Month 7 Day 10 Year 1959
5. SEX Female
6. COLOR OR RACE Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3-27-1882
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Fred Jennings
14. MOTHER'S MAIDEN NAME Martha Bailey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Joseph Jennings Address Apna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis
DUE TO (b) Arterial sclerotic Hypertension
DUE TO (c) Cardiovascular Disease
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 28, 1959 to July 10, 1959 that I last saw the deceased alive on July 10, 1959, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE R. H. Richardson M.D. ADDRESS (Street, city or town, state) 110 Clay St Annapolis, Md. DATE SIGNED 7/13/59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7-14-59
22c. NAME OF CEMETERY OR CREMATORY Chews Memorial
22d. LOCATION (City, town, or county) (State) Owensville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Lease, II ADDRESS Anna. Md.
24a. REC'D BY REGISTRAR DATE JUL 14 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7517

CERTIFICATE OF DEATH

Reg. Dist. No. 07482

1. PLACE OF DEATH
a. COUNTY AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedarhurst, Shadyside
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedarhurst, Shadyside, MD.
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: MAUDE Middle: JESSE Last: HARR

4. DATE OF DEATH: Month: July Day: 6 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 12/28/85
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months: 6 Days: 8
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hundred, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James M. McCullough
14. MOTHER'S MAIDEN NAME: ELIZABETH DAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lillian M. Fitzhugh, Address: Shadyside Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Colon (adenocarcinoma) — INTERVAL BETWEEN ONSET AND DEATH: 1 year +
153.8
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 1, 1959, to July 6, 1959, that I last saw the deceased alive on July 4, 1959, and that death occurred at 3 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F. Smith M.D. ADDRESS (Street, city or town, state): Shadyside, Md. DATE SIGNED: 7/6/59

PHYSICIAN'S NAME (Type): WILLARD F. SMITH, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/10/59
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn
22d. LOCATION (City, town, or county) (State): FAIRMOUNT W VA.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty ADDRESS: Galesville Md.

24a. REC'D BY REGISTRAR DATE JUL 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7518 Items 8,9 FilmG246 8-14-59 et

07483

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 21 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: Balto-city.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 101 N. Bond Street.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Hertie — Middle: — Last: Harris

4. DATE OF DEATH: Month: 7 — Day: 25 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: C.

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/90/8 1904 ?

8. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Isador~~ Robert Harris

14. MOTHER'S MAIDEN NAME: Nellie.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

INFORMANT: Hospital records — Address: Crownsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypoxia
4341
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Congestive heart failure.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: few days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SCHIZOPHRENIC REACTION - CATATONIC TYPE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/6, 19 58 to 7/25, 19 59 that I last saw the deceased alive on 7/25/59, 19, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: K. Benedict M.D. — M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital — DATE SIGNED

PHYSICIAN'S NAME (Type): C. Benedict M.D. — Crownsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 7/28/59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.

22d. LOCATION (City, town, or county) (State): Cedar Hill, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. O. Wilson — ADDRESS: 1000 Brantley Ave.

24a. REC'D BY REGISTRAR DATE: AUG 5 '59

24b. REGISTRAR'S SIGNATURE: Cullum & Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7519

Reg. Dist. No. 07484

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fair Haven
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Charles Middle: Herbert Last: Johnson
4. DATE OF DEATH Month: 7 Day: 30 Year: 1959
5. SEX Male
6. COLOR OR RACE Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-9-1942
9. AGE (In years last birthday) 17 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Beverly Beach
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Herbert Johnson
14. MOTHER'S MAIDEN NAME Josephine Franklin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Josephine Mackell Address Harwood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-1-59
22c. NAME OF CEMETERY OR CREMATORY Moses
22d. LOCATION (City, town, or county) Drewery, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
24a. REC'D BY REGISTRAR DATE AUG 3 '59
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7479

CERTIFICATE OF DEATH

07485

Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

063

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b: 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Edgewater
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Anne Arundel General Hospital	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
John	Wesley	JONES	July	21	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro		November 30, 1907	51 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintenance	St. Rd. Comm.	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Josiah Jones	Bertha Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	Address
No	214-16-5914	Irene Brown	Davidsonville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis and Portal Hypertension — INTERVAL BETWEEN ONSET AND DEATH

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Hepatorenal Vascular disease — 10 days

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Left lower lobe Pneumonia — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from July 11, 1959, to July 20, 1959, that I last saw the deceased alive on July 20, 1959, and that death occurred at 3:42A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Richardson M.D. — ADDRESS (Street, city or town, state): 110 Clay St., — DATE SIGNED: 7/21/59

PHYSICIAN'S NAME (Type) R. L. Richardson — Annapolis, Md.

1

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7-24-59	Chews Memorial	Owensville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. RECD BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
William Reese, Jr.	Arnold, Md.	JUL 22 '59	Clarence B. Hanna

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7520

CERTIFICATE OF DEATH

07486

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RIVA GUEST HOUSE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1131 Tyler Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE — Middle I — Last KNADLER

4. DATE OF DEATH: Month July — Day 26 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 9, 1885

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): N Y C

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Phillip Phelps

14. MOTHER'S MAIDEN NAME: Reggina (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-09-9577

INFORMANT: Mrs Wilbur H. McNew Sr.- Daughter* — Address: 742 Warren Dr Annapolis, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b): Coma — 4 days
DUE TO
(c): Multiple cerebrovascular Thrombosis — 7 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1955, to July, 1959, that I last saw the deceased alive on June 23, 1959, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John A Hedeman M.D.
ADDRESS (Street, city or town, state): 121 Cathedral Annapolis Md
DATE SIGNED: 7/27/59

PHYSICIAN'S NAME (Type): John Hedeman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 29, 1959
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home
ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: JUL 29 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Hance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7521

CERTIFICATE OF DEATH

07487

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8483 Ft. Smallwood Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Essex 03542
d. STREET ADDRESS: 23 Terrace Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle J Last KRALL

4. DATE OF DEATH: Month JULY Day 9 Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/1/1904

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unkonwn

10b. KIND OF BUSINESS OR INDUSTRY: Beth. Steel

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Catherine McCullough Krall, wife, above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

420.1

DUE TO (b) CORONARY INSUFFICIENCY — 2 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from —, 19____, to —, 19____, that I last saw the deceased alive on —, 19____, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Lankford Jr M.D. — ADDRESS (Street, city or town, state): Mountain Rd — DATE SIGNED

PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR MD. Pasadena Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/13/59

22c. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Schimunek — ADDRESS: Funeral Home 3331 Brehms Lane

24a. REC'D BY REGISTRAR DATE: JUL 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7523 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Reg. Dist. No. 07488

M

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jct. Staterts. 177 and 648

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pt. Pleasant
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Ernest Middle: T Last: Martin

4. DATE OF DEATH Month: July Day: 4 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct.11,1894

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?

I

13. FATHER'S NAME: Isaac Martin

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Philip Rosenberg,610 Washington Blvd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries — INTERVAL BETWEEN ONSET AND DEATH

812 X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by auto while walking.

20c. TIME OF INJURY Hour a. m. 2:25 xxxx Month, Day, Year July 4 1959

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street

20f. (City or town) (County) (State) Pasadena Anne Arundel Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Charles S Petty M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED 7/4/59

EXAMINER'S NAME (Type) Charles S. Petty

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 7-15-59

22c. NAME OF CEMETERY OR CREMATORY St.Peter's Cemetery

22d. LOCATION (City, town, or county) (State) Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William Cook, Inc., 1217 St.Paul Street

24a. REC'D BY REGISTRAR DATE JUL 16 '59

24b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7522

CERTIFICATE OF DEATH

Reg. Dist. No. 07489

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater Md
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Edgewater Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Katherine — Middle Beach — Last McBride

4. DATE OF DEATH: Month July — Day 31 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Jan 19, 1900
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): secretary
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Charles B-Mather
14. MOTHER'S MAIDEN NAME: Maude Stephens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Anita M Smith, Address: Edgewater Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Primary to cancer of left breast — 4 years
DUE TO
(c):

170 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 5, 1959, to July 31, 1959, that I last saw the deceased alive on July 31, 1959, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvia M Lim M.D. — ADDRESS (Street, city or town, state): R.F.D. 1, Box 277-M — DATE SIGNED: 7/31/59

PHYSICIAN'S NAME (Type): Sylvia M. Lim, Edgewater, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 3, 1959
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: F. Gaschs Sons Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE: AUG 3 '59
24b. REGISTRAR'S SIGNATURE: Clifton S. Mans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07490

7524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Edgewater P.O

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
d. STREET ADDRESS: Edgewater P.O.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Lacey — Last: McCarter

4. DATE OF DEATH: Month: July — Day: 6 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-12-1881

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): A A Co Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: James Francis Stallings

14. MOTHER'S MAIDEN NAME: Emma Harriett Wheeler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: James E. McCarter — Address: 143 Spa View Ave Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic hypertensive - — 7 years

DUE TO (c): Cardiovascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 27, 1958 to July 3, 1959, that I last saw the deceased alive on July 6, 1959, and that death occurred at 5:00 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvia M. Lim, M.D. — ADDRESS (Street, city or town, state): RFD #1 Box 277-M — DATE SIGNED: 7/6/59

PHYSICIAN'S NAME (Type): Sylvia M. Lim, — Edgewater, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): — 22b. DATE THEREOF: 7-8-59 — 22c. NAME OF CEMETERY OR CREMATORY: Mayo Mem Cemetery — 22d. LOCATION (City, town, or county): Mayo (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John M. Taylor Sons Annapolis Md

24a. REC'D BY REGISTRAR DATE: JUL 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kuhl

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG246 8-3-59 et

7480

CERTIFICATE OF DEATH

07491

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1 53 Lafayette Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

063

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: H — Last: MORGAN

4. DATE OF DEATH: Month: July — Day: 27 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec 21st 1873

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Salesman Ret

10b. KIND OF BUSINESS OR INDUSTRY: Merchant

11. BIRTHPLACE (State or foreign country): Winsted Conn

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James P. Morgan

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

INFORMANT: Mrs John Jacobson — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.

331X

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 23, 1959, to July 27, 1959, that I last saw the deceased alive on July 27, 1959, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N Peeler M.D.

ADDRESS (Street, city or town, state): 121 Cathedral St., Annapolis, Md.

DATE SIGNED: 7/28/59

PHYSICIAN'S NAME (Type): Richard N. Peeler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 30-59

22c. NAME OF CEMETERY OR CREMATORY: London Park Cemet

22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons

ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: JUL 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Item 18 Film 245 7-20-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7481

07492

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mayo
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

063

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
FRANK	THOMAS	NAYLOR	July	16	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Colored		2/18/1901	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Naylor, Sr.	Margarett Creek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	577-18-2690	James Naylor, Best Gate Rd., Annapolis, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction due to Coronary Thrombosis due to Arteriosclerotic Heart Disease

420.0

DUE TO X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Charles S Petty. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 7/17/59

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7-19-1959	Hillen's Chapel	Mayo Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Wm Reese #108 West St Annapolis Md.	JUL 21 '59	Arthur S Keene

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7482 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07493

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: AA Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA ANNE Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore. MD. 3Y01-4
d. STREET ADDRESS: 2416 Pelham Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Hubert Middle C Lost NICHOLSON
4. DATE OF DEATH: Month 7 Day 24 Year 1959
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 28 1911
9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OPERATOR
10b. KIND OF BUSINESS OR INDUSTRY: TRANSIT Co - BALTO
11. BIRTHPLACE (State or foreign country): Rock Mills Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: VINTON NICHOLSON
14. MOTHER'S MAIDEN NAME: SADIE White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 214-16-5835
17. INFORMANT: BERNADINE M. NICHOLSON Address: 630 YALE AVE BALTO 29 MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Struck by Lightning. — INTERVAL BETWEEN ONSET AND DEATH: Sudden
935.8
DUE TO (b): BURNS of Scalp - ANTERIOR chest -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Lower extremities - bilateral

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Struck by lightning
20c. TIME OF INJURY Hour —— a.m. p.m. Month, Day, Year: 7/24 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Town
20f. (City or town) (County) (State): AA Co.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. L. Wahrdt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): E. L. WAHRDT.
DATE SIGNED: 7-24-59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 28 JULY 1959
22c. NAME OF CEMETERY OR CREMATORY: BALTO NATIONAL
22d. LOCATION (City, town, or county) (State): BALTO MD

23. FUNERAL DIRECTOR'S SIGNATURE: J. H. C. & B. M. Walker
ADDRESS: Pratt & Stricker S/S
24a. REC'D BY REGISTRAR DATE: JUL 27 '59
24b. REGISTRAR'S SIGNATURE: Cathrine L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7483

CERTIFICATE OF DEATH

Reg. Dist. No. 07494

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5 Murray Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 5 Murray Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle W — Last NUTWELL

4. DATE OF DEATH: Month JULY — Day 28 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 25, 1872

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: City Water Company

11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Issac S. Nutwell

14. MOTHER'S MAIDEN NAME: Roberta Winterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 219-30-3591

INFORMANT: Mr. Stanton Nutwell- Son — Address: Severna Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocarditis — DUE TO

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 59, to July, 19 59, that I last saw the deceased alive on July 28, 19 59, and that death occurred at 6:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Elmer G. Linhardt M.D. — ADDRESS (Street, city or town, state): Annapolis, Maryland — DATE SIGNED: July 30, 1959

PHYSICIAN'S NAME (Type): Elmer G. Linhardt MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 31, 1959

22c. NAME OF CEMETERY OR CREMATORY: Mt Zion Cemetery

22d. LOCATION (City, town, or county) (State): Lothian, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hopping Funeral Home Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 3 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7484

Item10.13&14 FilmG244 7/16/59 cap

07495

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arudel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Crownsville, Maryland
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sadie — Middle: — Last: O'HARA

4. DATE OF DEATH: Month: July — Day: 8 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 7, 1885

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dietician

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Henry Edgell

14. MOTHER'S MAIDEN NAME: Henrietta Heather

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

157X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 24, 1959, to July 8, 1959, that I last saw the deceased alive on July 8, 1959, and that death occurred at 2:30PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Borssuck M.D. — ADDRESS (Street, city or town, state): Amos Garrett Blvd., — DATE SIGNED: 7/8/59

PHYSICIAN'S NAME (Type): Samuel Borssuck — Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/10/59

22c. NAME OF CEMETERY OR CREMATORY: Spring Hill

22d. LOCATION (City, town, or county) (State): Easton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.

24a. REC'D BY REGISTRAR — DATE: JUL 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7525

CERTIFICATE OF DEATH

07496

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 42yr.8mo.3da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 53 Spa Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Josephine; Middle: ; Last: Olney

4. DATE OF DEATH: Month: 7; Day: 27; Year: 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1893?

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Ridgley

14. MOTHER'S MAIDEN NAME: Susan West

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: - - -

INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 443X Hypostatic Pneumonia
DUE TO (b): Subarachnoid Hemorrhage
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c): Hypertensive Cardiovascular Disease associated with Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): -

20c. TIME OF INJURY Hour: - o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -

20f. (City or town) (County) (State): - - -

21. I certify that I attended the deceased from 11/24, 1916, to 7/27, 1959, that I last saw the deceased alive on 7/27/59, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 5/27/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M.D. — Crownsville State Hospital, Md. — 5/27/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-29-59

22c. NAME OF CEMETERY OR CREMATORY: Hope Chapel

22d. LOCATION (City, town, or county) (State): Edgewater, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, Jr. — ADDRESS: Arnold, Md.

24a. REC'D BY REGISTRAR DATE: JUL 29 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Hanna

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7485

CERTIFICATE OF DEATH

Reg. Dist. No. 07497

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 hr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X West River
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Agnes Middle MARION Last O'NEILL

4. DATE OF DEATH: Month July Day 3 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan 28 1872
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West River, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Phillip Mayhew
14. MOTHER'S MAIDEN NAME: Catherine JENKINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Joseph H. O'Neill, West River, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): generalized arteriosclerosis
DUE TO
(c): myocardial insufficiency

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct., 19 56, to July 3, 1959; that I last saw the deceased alive on July 2, 1959, and that death occurred at 12:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Mabin M.D.
ADDRESS (Street, city or town, state): Lothian, Md.
DATE SIGNED: 7-6-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/6/59
22c. NAME OF CEMETERY OR CREMATORY: Our Lady of Sorrows
22d. LOCATION (City, town, or county) (State): West River Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty
ADDRESS: Galesville Md.

24a. REC'D BY REGISTRAR DATE: JUL 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7526

CERTIFICATE OF DEATH

Reg. Dist. No. 07498

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft George G. Meade
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenelg 13x-2
d. STREET ADDRESS: [illegible] Maywood Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice — Middle: Gertrude — Last: Penn

4. DATE OF DEATH: Month: July — Day: 14 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 18 June 1890

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jefferson Jackson Brown

14. MOTHER'S MAIDEN NAME: Maggie Alice Massey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Brother: Address: S.J. Brown 107 Gilmore St, Baltimore, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Angiosarcoma, Metastatic — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
197.9
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 13 July, 19 59 to 14 July, 19 59, that I last saw the deceased alive on 14 July, 19 59, and that death occurred at 0255A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leon E Kassel M.D. — ADDRESS (Street, city or town, state): U.S.Army Hospital, Ft Meade, Md — DATE SIGNED: 14 Jul 59

PHYSICIAN'S NAME (Type): LEON E. KASSEL, MD, — U.S.Army Hospital, Ft Meade, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7-17-1959
22c. NAME OF CEMETERY OR CREMATORY: Morgan Chapel
22d. LOCATION (City, town, or county) (State): Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: C. M. Waltz, Winfield, Md.

24a. REC'D BY REGISTRAR DATE: JUL 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Hinkle

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7486

CERTIFICATE OF DEATH

07499

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

M 063 I

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XRURAL - Annapolis
d. STREET ADDRESS: Rt-2, Box-592
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Herbert — Middle: L — Last: PORTER

4. DATE OF DEATH: Month: July — Day: 12 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 31, 1910
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Walter Porter
14. MOTHER'S MAIDEN NAME: Blanche Griffin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-22-0518

INFORMANT: Frances Porter — Address: Sta Margaret Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemmhage due to
DUE TO (b): Hypertension's Cardiovascular disease
DUE TO (c):
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/12/59 (9 AM), 19 59, to 7/12/59 (10:00 PM), 19 59, that I last saw the deceased alive on 7/12/59, 19 59, and that death occurred at 10:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 110-C Hayes St Annapolis, Md — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-16-1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvery
22d. LOCATION (City, town, or county) (State): Arnold Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wm Reese #108 Wash St. Anna, Md.
24a. REC'D BY REGISTRAR — DATE: JUL 14 '59
24b. REGISTRAR'S SIGNATURE: Clifton S. Francis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7527

CERTIFICATE OF DEATH

07500

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2 years 11mo. 25days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3Y01-4
d. STREET ADDRESS: 1120 Barclay Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sadie; Middle: ; Last: Pratt

4. DATE OF DEATH: Month: 7; Day: 14; Year: 19 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1896?

9. AGE (In years last birthday): 63? yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Bronchopneumonia + Uremia
260X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Chronic Nephrosis
DUE TO
(c): Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) ----------

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----------

20f. (City or town) (County) (State) ----------

21. I certify that I attended the deceased from 7/19 19 56 to 7/14 19 59, that I last saw the deceased alive on 7/14 19 59, and that death occurred at 7:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 7/15/59

PHYSICIAN'S NAME (Type): L. Benedict, M. D.
Crownsville State Hospital, Md. 7/15/59

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 7-21-59

22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON

22d. LOCATION (City, town, or county) (State): ARLINGTON, VA.

23. FUNERAL DIRECTOR'S SIGNATURE: W. ERNEST JARVIS Co. ADDRESS: 1432 You ST. N.W.

24a. REC'D BY REGISTRAR DATE: JUL 20 '59

24b. REGISTRAR'S SIGNATURE: Arlina S. Knuse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7528 **CERTIFICATE OF DEATH** 07501

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION 6124 Gov Ritchie Hwy

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Cedar Hill
d. STREET ADDRESS 6124 Gov Ritchie Hwy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Margaret Middle Reynolds Last
4. DATE OF DEATH Month 7 Day 1 Year 1959

5. SEX Female
6. COLOR OR RACE Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH April 26
9. AGE (In years last birthday) 33 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Anne Arundel
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin Anderson
14. MOTHER'S MAIDEN NAME Daisey ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Address Walter Reynolds

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH several days

DUE TO (b) Carcinomata of Breast & Metastases — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Heat Exhaustion — One Day

170 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 10, 19 59, to July 1, 19 59, that I last saw the deceased alive on June 30, 19 59, and that death occurred at 7:00 A. M., from the causes and an the date stated abave.

ACTUAL SIGNATURE Richard H. Hunt M.D. ADDRESS (Street, city or town, state) July 2, 1959 DATE SIGNED

PHYSICIAN'S NAME (Type) RICHARD H. HUNT 100 Cherry Lane, Glen Burnie

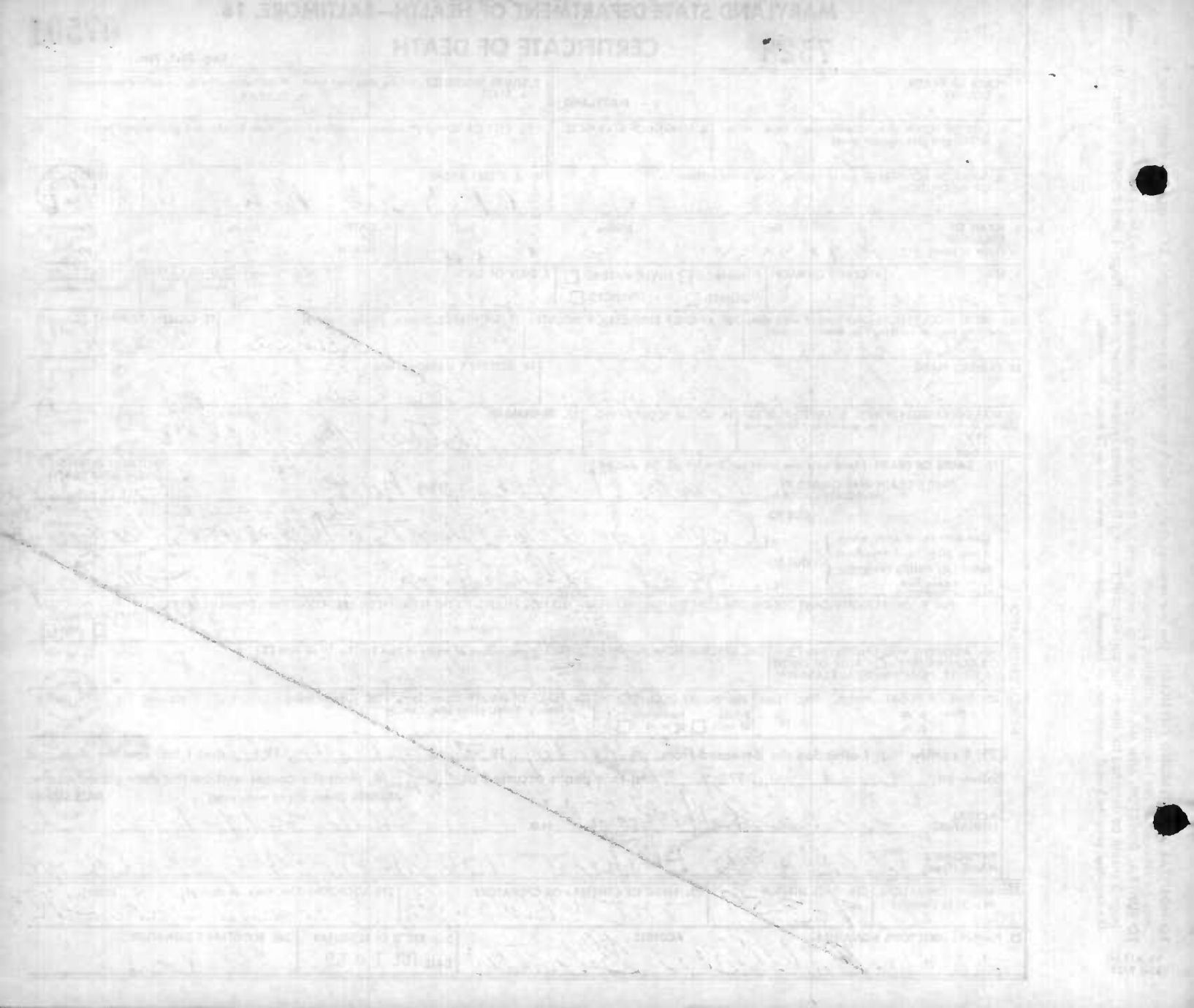
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7-3-59
22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Gdns
22d. LOCATION (City, town, or county) (State) Brooklyn Cedar Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE Thos O. Wilson ADDRESS Baltimore
24a. REC'D BY REGISTRAR DATE JUL 10 '59
24b. REGISTRAR'S SIGNATURE Esther J. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7529

CERTIFICATE OF DEATH

Reg. Dist. No. 07502

1. PLACE OF DEATH
a. COUNTY Anne Arundel County — OLEY F. RINGLER — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 Meadow Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY AA

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn

d. STREET ADDRESS 219 Meadow Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	OLEY	F.	RINGLER		7	3	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W		10/29/92	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Welder	USCG	W. Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Guy Ringler	Marian Spencer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	—		Family	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myeloid Leukemia	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO		
(c)		

204.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
a. m. / p. m. 19			

21. I certify that I attended the deceased from 1 April, 1959 to 3 July, 1959, that I last saw the deceased alive on 2 July 59, 19____, and that death occurred at 7.0 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Andrew R Sosnowski M.D. 4016 Ritchie Hwy (ADDRESS (Street, city or town, state)) 6 July 59 (DATE SIGNED)

PHYSICIAN'S NAME (Type) Andrew R. Sosnowski Balto-25-Md

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7/7/59	Cedar Hill Cem.	Brooklyn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
McCully Funeral Homes 130 E. Fort Ave.	JUL 8 '59	Arthur L Timmis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07503
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Schulte'Ford Dealer, N. Ritchie Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Odenton
d. STREET ADDRESS: Route 175
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Homer — Middle Lee — Last Ritz

4. DATE OF DEATH: Month July — Day 24th. — Year 1959

5. SEX: M.

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ ? DIVORCED ☒

8. DATE OF BIRTH: 1/31/14

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook and baker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Canton, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roy Ritz

14. MOTHER'S MAIDEN NAME: Margaret Gump

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): 11 World War (Army)

16. SOCIAL SECURITY NO.: 574-01-7894

17. INFORMANT — Address: Mr. Robert W. Kramer, 8 W. Barney St, Batimore, 1 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, X and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D.
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7/24/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7-30-59
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National
22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wm. Cook-Blight, 6009 Harford Road, ZONE 14

24a. REC'D BY REGISTRAR — DATE: JUL 29 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Krause

VS. A15ME
6M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7531

CERTIFICATE OF DEATH

07504

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 37 years 5mo. 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Louise — Middle — Last Robinson

4. DATE OF DEATH: Month 7 — Day 8 — Year 19 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 1893

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James M. Robinson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Thrombosis
DUE TO (c): Hypertensive Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----------

20c. TIME OF INJURY Month, Day, Year Hour ------ p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----------

20f. (City or town) (County) (State) ----------

21. I **certify** that I attended the deceased from 2/2, 1922, to 7/8, 1959, that I last saw the deceased alive on 7/8, 1959, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 7/8/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md. 7/8/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 7-9-59
22c. NAME OF CEMETERY OR CREMATORY: Md. School for Mentally Retarded, Camp Parkton
22d. LOCATION (City, town or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Milton Reese, U-Arsk. Md.

24a. REC'D BY REGISTRAR DATE: JUL 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7487 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07506

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA ANNE ARUNDEL GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 292 WEST STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle DANIEL Last SANDERS

4. DATE OF DEATH: Month JULY Day 2 Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 10, 1898
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. LT.
10b. KIND OF BUSINESS OR INDUSTRY: U.S.NAVY
11. BIRTHPLACE (State or foreign country): ANNAPOLIS, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM H. SANDERS
14. MOTHER'S MAIDEN NAME: CATHERINE A. DOUGHERTY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I and II
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT Address: RUBY LEE SANDERS - WIFE - same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY DISEASE — INTERVAL BETWEEN ONSET AND DEATH: YRS
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Natural Causes
20c. TIME OF INJURY Month, Day, Year: Hour ~~XXX~~ p. m. July 2 19 59
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Annapolis, Anne Arundel, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: July 2, 1959
EXAMINER'S NAME (Type): Elmer G. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 6, 1959
22c. NAME OF CEMETERY OR CREMATORY: St. Anne's Cemet ry
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: HOPPING FUNERAL HOME Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: JUL 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Hinds

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7532

CERTIFICATE OF DEATH

07507

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. Co — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md b. COUNTY: A. A. Co

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elvaton Hgts

c. LENGTH OF STAY IN 1b: 6 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elvaton Hgts

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Obrecht Rd - Rt 1 Box 758 A

d. STREET ADDRESS: Obrecht Rd Rt 1 Box 758 A

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY Middle J. Last SCHAEFER

4. DATE OF DEATH: Month July Day 13 Year 1959

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 17 Nov 1876

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOLDERER (Ret)

10b. KIND OF BUSINESS OR INDUSTRY: Enameling Co

11. BIRTHPLACE (State or foreign country): Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: HENRY SCHAEFER

14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-03-3083A

17. INFORMANT: MARIE E. HEBLER Address: Obrecht Rd Rt 1 Box 758A

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days
331X
DUE TO
(b): generalized arteriosclerosis — several years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 15, 1953, to July 13, 1959, that I last saw the deceased alive on July 12, 1959, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): RFD 8 Box 474 Pasadena, Md. — DATE SIGNED: July 13, 1959

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 16 July 1959

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem

22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: H. C. & B. M. Walters Prah & Stricker $6

24a. REC'D BY REGISTRAR DATE: JUL 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7488

CERTIFICATE OF DEATH

07508

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 5 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Annapolis (Rural)

d. NAME OF HOSPITAL OR INSTITUTION: Anne Arundel General Hospital
d. STREET ADDRESS: Sparrows Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Oliver — Middle — Last SELLMAN
4. DATE OF DEATH: Month July — Day 15 — Year 1959

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 24, 1900
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Clay Sellman
14. MOTHER'S MAIDEN NAME: Rosie Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-01-0604
INFORMANT: Arthur Sellman — Address: 104 College Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Stomach with
DUE TO (b): Metastases to Liver, Regional
DUE TO (c): Acute Myocarditis, Congestive Failure, Lung
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary Edema
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from July 10, 1959, to July 14, 1959 that I last saw the deceased alive on July 14, 1959, and that death occurred at 3:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Richardson M.D.
ADDRESS (Street, city or town, state): 110 Clay St., Annapolis, Md.
DATE SIGNED: 7/15/59
PHYSICIAN'S NAME (Type): Raymond L. Richardson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-19-1959
22c. NAME OF CEMETERY OR CREMATORY: Williams Chapel
22d. LOCATION (City, town, or county) (State): Lothian Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Reese #108 Wash St Anna Md
ADDRESS

24a. REC'D BY REGISTRAR DATE: JUL 21 '59
24b. REGISTRAR'S SIGNATURE: Clifton S Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7533

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07509

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME BM 2/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold.
c. LENGTH OF STAY IN 1b: 2 1/2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 75

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mrs. Middle BERTHA JOSEPHINE Last SHOWE

4. DATE OF DEATH: Month July Day 4 Year 1959

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/14/88

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Henry Switzer

14. MOTHER'S MAIDEN NAME: Mary Josephine Lawrence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ------

17. INFORMANT: Address: Mr. Jean Wm. SHOWE (Son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

241 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Bronchial Asthma — 431
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Faubert M.D.

EXAMINER'S NAME (Type): GUSTAVE-H-FAUBERT-M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 7/4/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/7/59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: JUL 7 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kreps

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7489

CERTIFICATE OF DEATH

07510

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Galesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eva — Middle: Mae — Last: SMITH

4. DATE OF DEATH: Month: July — Day: 18 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 3, ~~1889~~ 1887

9. AGE (In years last birthday): ~~72~~ 71 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Kirchnar

14. MOTHER'S MAIDEN NAME: Maggie Joyce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

INFORMANT: Ernest H. Smith- Husband- same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral arteriosclerosis

331X

DUE TO (b): with brain hemorrhage.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 3, 1959, to July 18, 1959, that I last saw the deceased alive on July 18, 1959, and that death occurred at 10:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson M.D. — ADDRESS (Street, city or town, state): Lothian, Md. — DATE SIGNED: 7/20/59

PHYSICIAN'S NAME (Type): Emily H. Wilson — Lothian, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 21, 1959

22c. NAME OF CEMETERY OR CREMATORY: Woodfields Cemetery

22d. LOCATION (City, town, or county) (State): Galesville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hopping Funeral Home Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: JUL 22 '59

24b. REGISTRAR'S SIGNATURE: Carlton L. Hance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7490

CERTIFICATE OF DEATH

07511

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1200 West St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: A — Last: SMITH SR

4. DATE OF DEATH: Month: July — Day: 14 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 19, 1887

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor + Bldg.

10b. KIND OF BUSINESS OR INDUSTRY: Masonry Cont.

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Smith

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Katherine Rogers Smith — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma toxis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO (b): Carcinoma of Gall Bladder — 4 wks.
DUE TO (c):

155.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 5, 1958 to 7-14-, 1959, that I last saw the deceased alive on 7-14-1959, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.

ADDRESS (Street, city or town, state): 6 Shaw St., Annapolis, Md.

DATE SIGNED: 7/15/59

PHYSICIAN'S NAME (Type): James R. Martin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 17-59

22c. NAME OF CEMETERY OR CREMATORY: Glenhaven Memorial

22d. LOCATION (City, town, or county) (State): Glen Burnie Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: JUL 16 '59

24b. REGISTRAR'S SIGNATURE: Carlton E. Evans

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG244 7-17-59 et

7534

07512

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
c. LENGTH OF STAY IN 1b: 10 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LAUREL Md ROUTE 1
d. STREET ADDRESS: FORT MEADE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LAURA Middle — Last SPRUILL

4. DATE OF DEATH: Month JULY Day 11, Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV 14, 1893
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK
10b. KIND OF BUSINESS OR INDUSTRY: MAID
11. BIRTHPLACE (State or foreign country): WARREN Co. N. CAROLINA
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JOHN SPRUILL
14. MOTHER'S MAIDEN NAME: NANCY BOYD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 238-36-7047
17. INFORMANT: ELIZA HOLMAN
Address: ROUTE 1 BOX 160 LAUREL Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiac failure.
4341
DUE TO
(b): cardiac failure.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): cardiac failure.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-23, 1959, to 7-11, 1959, that I last saw the deceased alive on 7-6, 1959, and that death occurred at 1 P. M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Aldo Tiravanti M.D.

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: July 15/59
22c. NAME OF CEMETERY OR CREMATORY: ROANOKE CHAPEL
22d. LOCATION (City, town, or county) (State): WELDON N. CAROLINA

23. FUNERAL DIRECTOR'S SIGNATURE: Ridgley Selby
ADDRESS: Laurel Md

24a. REC'D BY REGISTRAR DATE JUL 14 '59
24b. REGISTRAR'S SIGNATURE: Cathrine L Krouse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7491

07513

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1½ months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Pasadena
d. STREET ADDRESS: RFD-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mamie — Middle (Mary Estelle) — Last STALLINGS

4. DATE OF DEATH: Month July — Day 17 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 26, 1886
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Anne Arundel Co., Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert L. Gray
14. MOTHER'S MAIDEN NAME: Mary E. Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Mr. Henry B. Stallings — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular disease
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Paralysis of stom.
DUE TO (c): and dyspn. [illegible]
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 7, 19 59, to July 17, 19 59 that I last saw the deceased alive on July 17, 1959, and that death occurred at 2:05 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Elmer G. Linhardt M.D.
ADDRESS (Street, city or town, state): 3 Chesapeake Ave., Annapolis, Md.
DATE SIGNED: 7/17/59
PHYSICIAN'S NAME (Type): Elmer G. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 20 July 1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Meth. Ch. Cem.
22d. LOCATION (City, town, or county) (State): Mt. Rd. Pasadena, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton
ADDRESS: Glen Burnie, Md
24a. REC'D BY REGISTRAR DATE: JUL 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7535

CERTIFICATE OF DEATH

07514

Reg. Dist. No. 27

1

M C I

a30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft George G. Meade
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville 13x-2
d. STREET ADDRESS: Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Lowell — Middle Thomas — Last Staubitz Jr

4. DATE OF DEATH: Month July — Day 9 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6 July 1959

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days 3 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lowell Thomas Staubitz

14. MOTHER'S MAIDEN NAME: Carlenda Elizabeth Timmons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mother — Address: Mrs Lowell Thomas Staubitz, Sykesville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity, 32 weeks — INTERVAL BETWEEN ONSET AND DEATH
776 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 July, 1959, to 9 July, 1959, that I last saw the deceased alive on 9 July, 1959, and that death occurred at 1230P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: Roger C Moyer Capt MC — M.D. — U.S. Army Hospital, Ft Meade, Md — 9 Jul 59

PHYSICIAN'S NAME (Type): ROGER C. MCYER, CAPT, MC, US ARMY HOSPITAL, FT GEORGE G. MEADE, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-12-59

22c. NAME OF CEMETERY OR CREMATORY: Freedom

22d. LOCATION (City, town, or county) (State): Eldersburg Carroll, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: JUL 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

2050201 XV 2

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07515

7492 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83x-3
d. STREET ADDRESS: 3025 N. Oakland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOROTHY Middle Lost SUMMERBELL

4. DATE OF DEATH: Month 7 Day 6 Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/17/19

9. AGE (In years last birthday): 40 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry L Selby.

14. MOTHER'S MAIDEN NAME: Lillie Simms.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: William E Summerbell. Address: 3025 N. Oakland St. Arl. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs

443X

DUE TO (b): Hypertensive cardiovascular disease — 17 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/5, 19 59 to 7/6, 19 59, that I last saw the deceased alive on 7/6, 19 59 and that death occurred at 12:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N. Peeler M.D. ADDRESS (Street, city or town, state): 121 CATHEDRAL ST DATE SIGNED: 7/6/59

PHYSICIAN'S NAME (Type): RICHARD N. PEELER ANNAPOLIS, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial.

22b. DATE THEREOF: 7/8/59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery. Fort Myer. Virginia.

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph F Birch, s Sons ADDRESS: 3034 M Street, N.W. Wash. 7, D.C.

24a. REC'D BY REGISTRAR: DATE JUL 8 '59

24b. REGISTRAR'S SIGNATURE: Cristina L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07516

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b: 13 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): [illegible] Beach

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNA ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X EDGEWATER
d. STREET ADDRESS: [illegible] PINE WHIFF BEACH
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAUDE Middle KEENER Last SWINDELL

4. DATE OF DEATH: Month July Day 24 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/31/83

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): TENNESSEE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES WILSON KEENER

14. MOTHER'S MAIDEN NAME: MARY JANE LEWIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mrs. Wm. C. MacMillan, Address 8416 Woodcliff Ct. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): 420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ~~a. m.~~ p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 7/27/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 7/28/59

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Prince Geo. County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Fiska.

ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE JUL 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7537

07517

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orchard Beach
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1220 Riverside Dr.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Orchard Beach
d. STREET ADDRESS: 1220 Riverside Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle G. — Last TAAFE

4. DATE OF DEATH: Month 7 — Day 6 — Year 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-10-98

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Taafe

14. MOTHER'S MAIDEN NAME: Lena —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Mrs Flora Taafe - Orchard Beach Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the throat — INTERVAL BETWEEN ONSET AND DEATH: 6 months

148X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from June 22, 1959, to July 6, 1959, that I last saw the deceased alive on July 5, 1959, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): RFD 8 Box 442 Pasadena, Md. — DATE SIGNED: July 6, 1959

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-9-59

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem

22d. LOCATION (City, town, or county) (State): Brooklyn MD

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCully Funeral Home 130 E Fort Ave

24a. RECD BY REGISTRAR DATE: JUL 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kinna

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7538

CERTIFICATE OF DEATH

07518

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BROOKLYN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4509 RITCHIE HIGHWAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 50 BROOKLYN
d. STREET ADDRESS: 1 4509 RITCHIE HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle O. Last TAYLOR

4. DATE OF DEATH: Month 7/20/59 Day Year 19

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/7/75
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRODUCE DEALER
10b. KIND OF BUSINESS OR INDUSTRY: SELF EMPLOYED
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JACKSON TAYLOR
14. MOTHER'S MAIDEN NAME: HATTIE PARKS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: FAMILY - SAME Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 Hours
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteria sclerotic Heart Disease — 2—3 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic hypertrophic arthritis (E/2)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/14, 19 59 to 7/20, 19 59, that I last saw the deceased alive on 7/20, 19 59, and that death occurred at 5 20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Deibel M.D. — ADDRESS (Street, city or town, state): 1226 Hanover St. Balto 30 Md — DATE SIGNED: 7/21/59
PHYSICIAN'S NAME (Type): HARRY DEIBEL M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: 7/23/59
22c. NAME OF CEMETERY OR CREMATORY: LOUDON PARK
22d. LOCATION (City, town, or county) (State): BALTIMORE

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: MCCULLY FUNERAL HOMES - 130 E. FORT AVE.
24a. REC'D BY REGISTRAR DATE: JUL 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7539

07519

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 9/20/1954 — 5 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Marylond — b. COUNTY: Balto - City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 1406 W Lanvale St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice — Middle: F. — Last: Thomas

4. DATE OF DEATH: Month: 7 — Day: 24 — Year: 1959

5. SEX: female

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: LEVERING BANTHEM unknown

14. MOTHER'S MAIDEN NAME: ELIZA unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

INFORMANT: Hospital record. — Address: Crownsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hrs
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertension
DUE TO
(c): Cerebral Embolus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic Reaction. undiff. type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/20/54, 19___, to 7/24/59, 19___, that I last saw the deceased alive on 7/24/59, 19___, and that death occurred at 8:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L Benedict M.D. — ADDRESS (Street, city or town, state): CROWNSVILLE STATE HOSPITAL — DATE SIGNED

PHYSICIAN'S NAME (Type): L. BENEDICT M.D — CROWNSVILLE, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/28/59

22c. NAME OF CEMETERY OR CREMATORY: MT AUBURN

22d. LOCATION (City, town, or county) (State): BALTO - MD

23. FUNERAL DIRECTOR'S SIGNATURE: Maslanka Hayes — ADDRESS: Balto Md

24a. REC'D BY REGISTRAR DATE: JUL 27 '59

24b. REGISTRAR'S SIGNATURE: Arthur J. Hayes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7540

CERTIFICATE OF DEATH

Reg. Dist. No. 07520

1

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 3 yr. 11 da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lothian
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

010

3. NAME OF DECEASED (Type or print): First Georgianna — Middle — Last (alias Thompson) Thomas

4. DATE OF DEATH: Month 7 — Day 31 — Year 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1892

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundress

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

1

13. FATHER'S NAME: Jimmy Jackson

14. MOTHER'S MAIDEN NAME: Georgianna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: - -

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia
443x
DUE TO: Hypertensive Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -

20c. TIME OF INJURY Hour a. m. p. m. - Month, Day, Year - 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -

20f. (City or town) - (County) - (State) -

21. I certify that I attended the deceased from 7/20, 1956, to 7/31, 1959, that I last saw the deceased alive on 7/31, 19 59, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville State Hosp., Md.
DATE SIGNED: 7/31/59

1

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M.D.
Crownsville State Hospital, Md. 7/31/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 3, 59
22c. NAME OF CEMETERY OR CREMATORY: Friendship Church Cem.
22d. LOCATION (City, town, or county): Friendship (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Leroy E. Berry
ADDRESS: Huntingtown, Md.

24a. REC'D BY REGISTRAR DATE: AUG 4 '59
24b. REGISTRAR'S SIGNATURE: Charles L. Howes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7541 — 07521 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 402 Melrose Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: AA Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Ferndale
d. STREET ADDRESS: 402 Melrose Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Albert — Middle H. — Last Thompson
4. DATE OF DEATH: Month July — Day 20/59 — Year 19

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 2, 1890
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Produce
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ---Thompson
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218 03 0131
INFORMANT: (daughter) Mrs. Alverta Gouldin, Address 402 Melrose Rd. Ferndale Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRO-VASCULAR HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): CEREBRAL ATHEROSCLEROSIS — 15YRS.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Doy, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-25, 1959, to 7-20, 1959, that I last saw the deceased alive on 7-10, 1959, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leon C. Perry M.D. — ADDRESS (Street, city or town, state): 201 B+A Blvd Glen Burnie, Md. — DATE SIGNED: 7-21-59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 23/59
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park
22d. LOCATION (City, town, or county) (State): Balto. 29, Md

23. NAME AND ADDRESS OF FUNERAL DIRECTOR: Witzke Funeral Directors, 4101 Edmondson Ave.
24a. REC'D BY REGISTRAR DATE: JUL 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7493 **CERTIFICATE OF DEATH** 07522

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Riva
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

063

3. NAME OF DECEASED (Type or print): First Mabel — Middle Merrick — Last Tilghman

4. DATE OF DEATH: Month July — Day 31 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 20, 1899
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (State or foreign country): Harford County, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Annie Miles Riley
14. MOTHER'S MAIDEN NAME: Caleb M. Merrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Thomas O. Tilghman Sr. Husband asme as # 2
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sundate
420.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/31/59 19___, to 7/31/ 19 59, that I last saw the deceased alive on ____, 19___, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Albert L. Anderson M.D.
ADDRESS (Street, city or town, state): Annapolis, Md.
DATE SIGNED: 7/31/59

PHYSICIAN'S NAME (Type): Dr. Albert L. Anderson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: AUGUST 2, 1959
22c. NAME OF CEMETERY OR CREMATORY: Southern Methodist Cemet.
22d. LOCATION (City, town, or county) (State): Dublin, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Hopping Funeral Home Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: AUG 3 '59
24b. REGISTRAR'S SIGNATURE: Clifton S. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7494 **CERTIFICATE OF DEATH** 07523

Reg. Dist. No.

1. **PLACE OF DEATH** a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: A A General

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 317 First St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Louis Middle Tompkins Last (Tomaszewski)
4. **DATE OF DEATH**: Month 7- Day 22 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 4-1895
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): joiner
10b. KIND OF BUSINESS OR INDUSTRY: Ship Yard
11. BIRTHPLACE (State or foreign country): Phila Pa
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Samuel Tomaszewski
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war, or dates of service): WW I
16. SOCIAL SECURITY NO.:
INFORMANT: Lillian Tompkins (2) Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis & Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 7 wks.
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Coronary Artery Disease — unknown
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Ventricular Tachycardia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 6-6, 1959, to 7-22, 1959, that I last saw the deceased alive on 7-22, 1959, and that death occurred at 1:25 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S Beck M.D. ADDRESS (Street, city or town, state): 4 Southgate Ave Annapolis, Md. DATE SIGNED: 7/27/59
PHYSICIAN'S NAME (Type): EDWARD S BECK

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-27-59
22c. NAME OF CEMETERY OR CREMATORY: U.S. Government Nat. Cem.
22d. LOCATION (City, town, or county): Beverly (State): N. J.

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Taylor Sons ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: JUL 27 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07524

7495 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General Hosp.

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East Port - Annapolis
d. STREET ADDRESS: 403 Chesapeake Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Clarence — Middle: A. — Last: Turner

4. **DATE OF DEATH**: Month: 7 — Day: 29 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-9-1911

9. AGE (In years last Birthday): 48 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Naval Acad

11. BIRTHPLACE (State or foreign country): East Port, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Solomon Turner

14. MOTHER'S MAIDEN NAME: Mary Blunt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-26-7616

INFORMANT: Catherine Turner — Address: East Port, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 day.

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive Vascular Disease — 2 yr

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 1/7, 1959, to 7/29, 1959, that I last saw the deceased alive on 7/29, 1959, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED: 7/30/59

ACTUAL SIGNATURE: Theodore H. Johnson M.D.

PHYSICIAN'S NAME (Type): DR. THEODORE H. JOHNSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-1-59

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, II — ADDRESS: Arnold, Md.

24a. REC'D BY REGISTRAR DATE: JUL 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7542

CERTIFICATE OF DEATH

07525

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Carrollton Manor.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rte 2, Box 547, Severna Park

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Carrollton Manor, Md
d. STREET ADDRESS: Knollwood Rd. Severna Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edwin Middle McClellen Warrenberger Last
4. DATE OF DEATH: Month 7 Day 30 Year 59 19

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 25 1904
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Balto. City.
11. BIRTHPLACE (State or foreign country): Baltimore. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Warrenberger
14. MOTHER'S MAIDEN NAME: Trimble

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 219-01-1986
17. INFORMANT: Wife Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure
527.1
DUE TO (b): Emphysemea (Pulmonary)
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1954, 19, to 1959, 19, that I last saw the deceased alive on 7-29-59, 19, and that death occurred at 4 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert Hahn M.D. ADDRESS (Street, city or town, state): Severna Park DATE SIGNED: 7-30-59

PHYSICIAN'S NAME (Type): Robert Hahn, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/1/59
22c. NAME OF CEMETERY OR CREMATORY: BALTIMORE
22d. LOCATION (City, town, or county) (State): BALTIMORE Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Kirkley ADDRESS: Hopping & Kirkley, Glen Burnie, Md

24a. REC'D BY REGISTRAR DATE: JUL 31 '59
24b. REGISTRAR'S SIGNATURE: Cullen E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7543

CERTIFICATE OF DEATH

Reg. Dist. No. 07525

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLERSVILLE
c. LENGTH OF STAY IN 1b: 2 MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SANN'S NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HERALD HARBOR
d. STREET ADDRESS: HAZEL TRAIL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eleonora — Middle: — Last: Willner

4. DATE OF DEATH: Month: 7 — Day: 30 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/14/1880

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ROBERT E. SCAGGS

14. MOTHER'S MAIDEN NAME: PETERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

INFORMANT: Jean Williams — Address: Millersville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

490X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1-59 to July 30-59, that I last saw the deceased alive on July 29-59, and that death occurred at 5:30 AM from the causes and an the date stated above.

ACTUAL SIGNATURE: Joseph Lipsky M.D.

ADDRESS (Street, city or town, state): Odenton Md.

DATE SIGNED: 7/30-59

PHYSICIAN'S NAME (Type): DR. JOSEPH LIPSKY, ODENTON, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 3, 1959

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home

ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 3 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7496

07527 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 184 Duke of Gloucester
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: E. — Last: WINCHESTER

4. DATE OF DEATH: Month: July — Day: 28 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 28, 1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Patrick Lamb

14. MOTHER'S MAIDEN NAME: Bridget Hogan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Francis O. Winchester — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Azotemia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Chronic Glomerular Nephritis — 1 yr.
DUE TO (c): arteriosclerosis Generalized — 4 yrs.
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1955, to July 28, 1959, that I last saw the deceased alive on July 28, 1959, and that death occurred at 5:10 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.
ADDRESS (Street, city or town, state): 6 Shaw St., Annapolis, Md.
DATE SIGNED: 7/29/59
PHYSICIAN'S NAME (Type): James R. Martin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 31-59
22c. NAME OF CEMETERY OR CREMATORY: St Mary's Cem
22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: JUL 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 FilmG246 7-31-59 et

7544

CERTIFICATE OF DEATH

07528

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sauns Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Severn
d. STREET ADDRESS Maryland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Ruth Middle Nellie Last Wooden

4. DATE OF DEATH Month July Day 25 Year 1959

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 13 Aug. 99
9. AGE (In years last birthday) 59 yrs.
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. Wife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) USA Johnstown, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Howard W. Walton
14. MOTHER'S MAIDEN NAME Nellie Leightner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Wilbur E. Wooden Address Severn Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub Arachnoid Hemorrage — INTERVAL BETWEEN ONSET AND DEATH

443X

DUE TO (b) Hypertensive Cardio Vascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Sclerotic Cardio Vascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1959 to July 23, 1959, that I last saw the deceased alive on July 23, 1959, and that death occurred at 4.30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Febus Greenberg M.D. ADDRESS (Street, city or town, state) P.O. Box 37 DATE SIGNED 7/24/1959

PHYSICIAN'S NAME (Type) Febus Greenberg Odenton, Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 27 July 59
22c. NAME OF CEMETERY OR CREMATORY Glen Haven
22d. LOCATION (City, town, or county) (State) Glen Burnie Md.

23. FUNERAL DIRECTOR'S SIGNATURE R. J. Dingle Sons ADDRESS Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE JUL 27 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Krug

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG244 7-21-59 et

7497

CERTIFICATE OF DEATH

07529 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1 731 Glenwood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sarah — Middle — Last ZELKOWITZ

4. DATE OF DEATH: Month July — Day 10 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 15, 1866 (1876)
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown Block
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebrovascular cardiovascular disease — 5 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 4, 1959, to July 10, 1959, that I last saw the deceased alive on July 10, 1959, and that death occurred at 12:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John Hedeman M.D. — ADDRESS (Street, city or town, state): 121 Cathedral St., Annapolis, Maryland — DATE SIGNED: 7/11/59

PHYSICIAN'S NAME (Type): John Hedeman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 12, 1959
22c. NAME OF CEMETERY OR CREMATORY: Kneseth Israel Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: JUL 16 '59
24b. REGISTRAR'S SIGNATURE: Clinton L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58